Leighton (A. W.)

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FOR

OVARIAN CYST.

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NEW HAVEN, CONN.

[From the Proceedings of the Connecticut Medical Society, 1885.]

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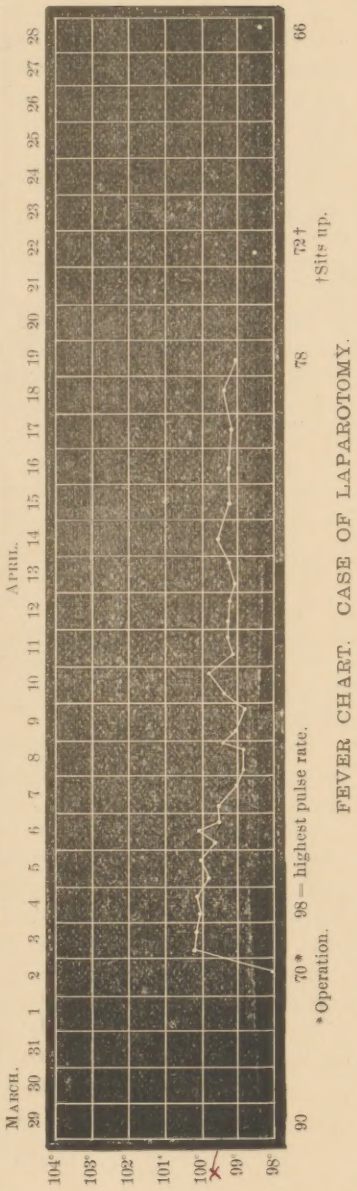
Mrs. C. H., aet. 55, mother of four boys—experienced the menopause normally at the age of 45. General health always delicate, but as good as usual last July (1884) when she first noticed that her abdomen was enlarging. In the following December she permitted a physician to tap her with a trocar at his office. Following this came peritonitis from which she was thought to be dying when I first saw her. At this time the uterus was atrophied, drawn strongly up against the promontory of the sacrum and was nearly fixed in position. The os uteri was widely agape. There was no evidence of recent or remote pelvic disease. I diagnosticated circumscribed peritonitis about the site of the abdominal puncture, and ovarian cyst as the primary disease. Two weeks later she had recovered from the peritonitis, but suffered greatly from dyspnœa and dyspepsia, and as she utterly declined operative interference, I aspirated five quarts of fluid of the following description, through a needle cleaned with liquified carbolic acid: S. Gr. 1010, pale straw color, flows like linseed tea;—is not sticky between the fingers,—no sedimentation at the end of twenty-four hours;—contains albumen.

The patient rapidly improved after aspiration, but the benefit proved only temporary. The left leg began to swell. The abdomen refilled. March 11, 1885, I aspirated antiseptically three quarts of liquid which was much thicker and darker than before. Again temporary relief gave place to extreme feebleness, and, educated by experience, the patient finally submitted to the knife. Repeated examinations had established my diagnosis. I believed the pedicle to be the left broad ligament con-

siderably elongated. The previous history indicated extensive adhesions at least anteriorly.

On April 2d, assisted by Drs. Gustavus Eliot and Robert T. Morris I performed laparotomy and removed the cyst, finding the lesions as expected.

The operation lasted one hour and five minutes, and the patient made a rapid and complete recovery as is partially indicated by the subjoined chart, where it is seen that she left her bed on the twentieth day. By the aid of a hypodermic injection of $\frac{1}{3}$ gr. morphia, anæsthesia was maintained with less than six ounces of ether, and the patient dozed quietly until evening. I employed strict antiseptic precautions and permanent dressings which were removed on the fourteenth day when everything was found healed and clean with no trace of pus. The patient is now attending to her household duties, and enjoying better health than for many years.



FEVER CHART. CASE OF LAPAROTOMY.

The phrase — antiseptic precautions—is commonly used to express measures of a varied and often indefinite nature. In order to be more exact I will briefly outline the chief points attended to.

The operating room was thoroughly scoured a week in advance, closed from the rest of the house, and left to air with windows open and a hot fire. All necessary utensils basins, tables, etc., were likewise, cleaned and collected in this room. The patient took a bath the day before the operation, and fresh clothing and bedding were provided. All instruments, sponges, etc., were carefully cleaned,—in a word what may be called gross cleanliness was first of all secured.

As to special germicidal precautions all towels were prepared by prolonged boiling, soaking in bi-chloride of mercury solution,—sol. 1, and ironing. Sponges stood in glass jar of sol. 1, until the moment of using. All instruments were boiled in boro-salicylic acid solution,—sol. 2, dried with and wrapped in a prepared towel till the operation when they stood in sol. 2.

Early in the morning of the operation the patient's abdomen was shaven, the abdomen and navel cleaned with sol. 1, and a compress of the same fluid left in situ until the moment of cutting. The surgeons' hands were soaked in sol. 1, prepared towels freshly wrung out of sol. 1 were spread all about the abdomen before the incision was made, and the latter was irrigated with sponges dripping with sol. 2. When the sac was reached the lips of the wound were smeared with carbolized vaseline, the sac was slit open, the woman turned on her side and the contents allowed to escape. The sac was then packed with prepared sponges to facilitate handling and guard against leakage of contents. The pedicle was tied with stout catgut soaked in ol. juniper, and afterwards in alcohol, and two arteries were ligated with the same material, the stump being returned to the peritoneal cavity which was then cleansed with fresh sol. 2, and sponges.

The incision was closed with four sets of interrupted catgut sutures uniting respectively the peritoneum, linea alba, deep cellular tissue and skin.

The skin was then washed with sol. 1, and dusted with iodoform, a strip of protective silk being placed along the incision to prevent adhesion to the dressings.

Next came a drainage compress of bichloride gauze, then a layer of borated cotton, and finally a sheet of protective silk under a tightly applied abdominal bandage.

When these dressings were removed on the 14th day, the knots of those sutures that were tied externally lay loose upon the skin, all else having been absorbed. Two days later the cicatrix was felt to be solid throughout. The presumption is that after fulfilling their function, the pedicle ligatures were also absorbed.

In closing it may be well to note that an examination of the cyst wall revealed the fact that the site of my needle punctures was free from adhesions, contrasting strongly with the evidences of peritonitis set up by the trocar. In this case aspiration did much to prepare the patient for operation, besides very materially facilitating a correct diagnosis.